Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375123 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/15/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Memorial Heights Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1305 Southeast Adams Idabel, OK 74745 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review, and interview, the facility failed to ensure:a. proper final cooking temperatures were monitored to check the internal temperature was safe for consumption prior to placing on the steam table for holding before meal service; andb. a log was maintained to reflect the monitoring of final cooking temperatures and holding temperatures for 1 meal service observed. The compliance officer identified 86 residents resided in the facility.Findings:A Position Description Dietary Service Manager, read in part, Assures correct procedures in preparation of food and inspects quality, temperature, and appearance of food prior to serving.On 04/14/26 at 10:32 a.m., an observation was made of peas cooking on the stove, roast beef was in the oven, rolls were rising on the counter, and rice was on the stove. On 04/14/26 at 10:35 a.m., the dietary manager was observed to prepare puree roast with a piece from the pan in the oven and the juice from the pan. There was no observation the dietary manager obtained a temperature of the roast.On 04/14/26 at 10:46 a.m., the dietary manager was observed to puree the peas with the water it was cooked in. There was no observation the dietary manager obtained a temperature of the peas.On 04/14/26 at 10:55 a.m., the dietary manager was observed to puree the rice pilaf with chicken paste and hot water.There was no observation the dietary manager obtained a temperature of the rice.On 04/14/26 at 11:08 a.m., the dietary manager was observed to remove the roast from the oven and placed on the steam table.There was no observation the dietary manager obtained a temperature of the roast. On 04/14/26 at 11:30 a.m., the dietary manager was observed to grab the thermometer and the temperature book and obtained a temperature of the roast at 209 degrees Fahrenheit. The temperature book showed a page for the month of April. The temperature book showed one temperature documented for each meal item for breakfast, lunch. and dinner. The page was blank for all meals from 04/09/26 through 04/14/26. On 04/14/26 at 11:34 a.m., the dietary manager stated they had the breakfast and lunch cooking temperatures wrote down on paper and they were not the evening cook. The dietary manager stated they left the paper in their bag at home.On 4/14/26 at 11:35 a.m., [NAME] #1 stated they were the evening cook, and they had not done the temperatures. On 04/14/26 at 11:36 a.m., the dietary manager stated they cooked the food, placed it on the steam table, and then obtained the temperature of the food. They stated they had not obtained cooking temperatures prior to placing the food on the steam table. On 04/14/26 at 11:39 a.m., the dietary manager stated they were told back in 2020 to cook the food and put it on the steam table and to check the temperature at the steam table. [NAME] #1 stated they were told the same.The dietary manager and cook #1 were asked how they ensured proper cooking temperatures were reached after cooking. They were unable to state how proper cooking temperatures were ensured. On 04/14/26 at 12:50 p.m., the compliance officer stated the cooks were educated to obtain temperatures of the food after cooking and were not required to document the temperature. The compliance officer stated once the food was on the steam table, they were to obtain and document the holding temperature. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident representatives were notified of a change in condition for 2 (#98 and #100) of 3 sampled residents reviewed for change of condition. The administrator identified 86 residents resided in the facility. Findings:<br><br>An undated facility Notification of Changes policy read in part, The facility must immediately inform.The resident representative(s) when there is.A significant change in the resident's physical, mental or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).<br><br>A nursing note, dated 10/05/25 at 12:58 a.m., showed Resident #98 received cardiopulmonary resuscitation at the facility and emergency medical services transported the resident to the hospital at 1:03 a.m.<br><br>There was no documentation Resident #98's representative was notified of the change in condition and transfer to the hospital on [DATE].<br><br>On 04/09/26 at 6:23 p.m., LPN #1 stated they were to notify their supervisor and a resident's on-call physician of a change in condition.<br><br>On 04/09/26 at 6:32 p.m., LPN #1 stated they did not recall documenting the resident's family was notified of the change in condition.<br><br>On 04/10/26 at 8:58 a.m., resident representative #1 stated they were not notified of Resident #98's change in condition or transfer to the hospital.<br><br>On 04/10/26 at 9:08 a.m., the DON stated staff were to notify the resident's physician and family of a change in condition.<br><br>On 04/10/26 at 9:10 a.m., the DON stated they could not locate documentation resident #98's family was notified of the change in condition on 10/05/25.<br><br>2. A nurses note, dated 02/24/26 at 4:45 a.m., showed Resident #100 was observed in a seated position on the floor in their room with their head against the bed rail. The nurse note showed Resident #100 stated they fell while going to the bathroom and hit their head. The nurse note showed the facility was unable to locate the contact information for Resident #100's next of kin. The nurse note showed Resident #100 had sustained a large hematoma to their right elbow and right inner forearm, a skin tear to left inner wrist, and an abrasion to their left knee.<br><br>There was no documentation Resident #100's next of kin was notified of the change in condition and transfer to the hospital.<br><br>A miscellaneous section of the EMR showed the admission paperwork with Resident #100's family member's name and phone number written on it was uploaded on 02/24/26 at 7:48 a.m.<br><br>The contact history in the EMR showed the date and time Resident #100's family member was listed<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | as a contact was entered on 02/24/26 at 8:50 a.m.<br><br>An Oklahoma State Department of Health Incident Report Form, dated 02/24/26, showed Resident #100's family member was at the facility at 7:30 a.m., and 8:20 a.m., and spoke to both the DON and the administrator about the resident's fall.<br><br>On 04/13/26 at 3:03 p.m., the DON stated the process for sending residents out to the hospital for a change in condition was to assess the resident and if warranted they would notify the physician, then EMS, and then would notify the family and the hospital. The DON stated the process for uploading new admission contact information was to enter it in the misc. section of the EMR or documents tab at the time of completing the admission.<br><br>On 04/13/26 at 3:04 p.m., the DON stated the contact information for Resident #100 was uploaded to the EMR on 02/24/25 at 8:34 a.m.<br><br>On 04/13/26 at 3:06 p.m., the DON stated when Resident #100 fell, they looked for the contact information for the family member. They stated the contact information was not in the profile in the EMR, or in the discharge paperwork. The DON stated the next morning after the fall when they saw Resident #100's family member in the facility, they notified them in person of the resident's fall and having been sent to the hospital. The DON stated whoever had gotten the contact information had not uploaded it.<br><br>On 04/13/26 at 3:13 p.m., the DON stated the nurse that admitted Resident #100 had forgotten to upload the information. They stated they found out when the family member came in that the paperwork with the contact information on it was in a binder/folder in the medication room where the nurse that did the admission had left it. The DON stated since the resident was admitted after hours, the charge nurse was responsible for the admission paperwork. The DON stated Resident #100's family member was not notified at 4:45 a.m., when the resident was sent out to the hospital. The DON stated the family member was notified around 8:00 a.m., when they came to the facility.<br><br>On 04/13/26 at 3:15 p.m., the DON stated it was not the usual process to store resident contact information in a folder in the medication room. They stated they would give it to the admission person. But they had left for the day. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on record review and interview, the facility failed to ensure catheter care was performed for an indwelling catheter for 1 (#10) of 3 sampled residents reviewed for urinary catheter.The compliance officer identified 6 residents with a urinary catheter resided in the facility. Findings: An undated policy titled Incontinence, read in part, Ensure that a resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible. A physician order, dated 09/17/25, showed catheter to gravity. A physician order, dated 11/25/25, showed to change catheter every month. There were no orders for catheter care located in the EMR. A quarterly assessment for Resident #10, dated 12/30/25, showed the brief interview for mental status score of 13 indicating cognitively intact. The assessment showed Resident #10 required partial to moderate assistance with mobility and was dependent with toileting due to indwelling urinary catheter and ileostomy. The assessment showed a diagnosis of urinary retention and a urinary tract infection within the last 30 days. Resident #10's care plan, dated 01/30/26, did not show the resident performed their own catheter care and did not indicate staff would provide catheter care. On 04/08/26 at 1:15 p.m., Resident #10 stated staff changed their catheter monthly but did not provide any catheter care. Resident #10 stated they performed their own peri care and catheter care. On 04/15/26 9:54 a.m., Resident #10 stated they did their own catheter care everyday using a washcloth. They stated it was not their preference to do the catheter care. Resident #10 stated the reason they do it was to keep it clean and germ free and did not know why the facility staff did not perform the catheter care. On 04/15/26 at 10:13 a.m., LPN #2 stated the resident received catheter care every shift. They stated they provided catheter care for the resident. LPN #2 stated they had to sign off on the treatment sheet for the catheter care and there should be an order for it. On 04/15/26 at 10:19 a.m., LPN #2 stated the resident should not do their own catheter care. On 04/15/26 at 10:17 a.m., LPN #2 stated there was no order for catheter care but there should have been. On 04/15/26 at 10:24 a.m., the DON stated the catheter care order would be in the orders or in the tasks. They stated the CNA did the catheter care. The DON stated the orders did not show catheter care and the task did not show where it was documented. The DON stated catheter care should have been documented. On 04/15/26 at 10:28 a.m., the DON stated they did not see an order for catheter care and there should have been one. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on record review and interview, the facility failed to ensure before and after dialysis assessments and weights were obtained for 1 (#26) of 1 sampled resident reviewed for dialysis. The administrator identified 6 dialysis residents resided in the facility. Findings:A policy titled Dialysis, undated, read in part, The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice. Ongoing assessments of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.A physician's order, dated 01/23/26, showed assess dialysis site to right chest every day and night shift.A physician's order, dated 01/24/26, showed hemodialysis every day shift every Tuesday, Thursday, and Saturday.A physician's order, dated 01/24/26, showed weigh before and after dialysis every day shift every Tuesday, Thursday, and Saturday.An admission assessment for Resident #26, dated 02/04/26, showed the resident had a diagnosis of renal failure. The assessment showed they received dialysis while a resident.There was no before and after dialysis assessments documentation for (Tuesday) 03/31/26, (Thursday) 04/02/26, and (Saturday) 04/04/26. There were no weights located for before and after dialysis. On 04/09/26 at 3:28 p.m., LPN #3 stated prior to residents going to dialysis, there was a head-to-toe assessment completed before each treatment and the documentation was on paper and scanned into the EMR. They stated a form was sent with the resident for the dialysis center to complete and return with the resident and then it was scanned into the EMR. On 04/09/26 at 3:45 p.m., LPN #3 stated they were unable to locate before and after dialysis documentation for 03/31/26, 04/02/26, or 04/04/26, and they did not see documentation of refusal to go to dialysis on the days in question. On 04/09/26 at 3:47 p.m., LPN #3 stated the before and after weights were in the weights section of the EMR. They stated it was only flagged for after dialysis and not before dialysis. LPN #3 stated the weights should have been on the treatment sheet, but the order had been entered incorrectly and did not show up. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, record review, and interview, the facility failed to ensure the call light was within reach for 1 (#84) of 18 sampled residents observed for call lights within reach. The administrator identified 86 residents resided in the facility. Findings: On 04/08/2026 at 10:50 a.m., Resident #84 was observed in bed. The call light was observed on the floor behind the resident's head of bed. On 04/08/26 at 11:14 a.m., CNA #6 went into Resident #84 room and picked up the call light from the floor behind the resident's head of bed. A policy titled Call Light, Use of, undated, read in part, All facility personnel must be aware of call lights at ALL times. Be sure all call lights are placed within the reach of each resident, never on the floor or bedside stand. On 04/08/26 at 10:51 a.m., Resident #84 stated they would yell out when they needed assistance. On 04/08/26 at 11:12 a.m., CNA #6 stated Resident #84 required two people for assistance with activities of daily living. They stated Resident #84 was able to use a call light. CNA #6 stated the call light was kept within residents' reach. They stated call lights were given to residents before they left the rooms; and checks were completed on the resident call lights constantly. On 04/08/26 at 11:15 a.m., The CNA stated the call light was on the floor and not within the reach of Resident #84. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on record review and interview, the facility failed to ensure a resident's discharge assessment was completed and transmitted for 1 (#74) of 18 sampled residents reviewed for assessments. The compliance officer identified 29 residents had discharged from the facility since 11/2025.Findings: Resident #74's electronic record, under the diagnoses tab, showed Resident #74 had diagnoses which included fracture of the left femur, hypertension, and edema. A Post-Discharge Plan of Care, dated 02/28/26, showed Resident #74 was discharged to home. There was no documentation a discharge resident assessment was completed. On 04/13/26 at 11:31 a.m., the DON stated the MDS coordinator was responsible for the completion of MDS assessments. On 04/13/26 at 11:40 a.m., the administrator reviewed the electronic record for Resident #74. The administrator stated the discharge assessment for Resident #74 had not been completed and should have been completed. The administrator stated ultimately, they were responsible for ensuring the MDS was completed. The administrator stated they were the RN who signed off for completed MDS assessments. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review and interview, the facility failed to ensure a care plan was developed to address hospice services for 1 (#60) of 1 sampled resident reviewed for hospice services. The compliance office identified 11 residents who received hospice services resided in the facility.Findings:An undated facility policy titled Comprehensive Care Plan, read in part, Each resident will have a person-centered comprehensive care plan developed and implemented to meet [their] preferences and goals and address the resident's medical, physical, mental and psychosocial needs.A hospice physician's order, revised 07/07/25, showed Resident #60 started hospice on 04/17/25.Resident #60's quarterly assessment, dated 01/18/26, showed Resident #60 had a diagnosis of chronic obstructive pulmonary disease and received hospice services.Resident #60's care plan, revised on 01/30/26, did not address hospice services.On 04/15/26 at 11:48 a.m., the DON stated Resident #60's care plan did not include hospice interventions.On 04/15/26 at 11:53 a.m., the DON stated Resident #60 started hospice services on 04/17/25. On 04/15/26 at 12:17 p.m., the administrator stated Resident #60's care plan should include hospice interventions.On 04/15/26 at 12:18 p.m., the administrator stated Resident #60's care plan did not include hospice interventions. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, record review, and interview, the facility failed to ensure medication was stored separate from personal food and drinks items for 2 of 2 refrigerators observed in the medication room. The DON identified the facility had one medication room. Findings: On 04/13/26 at 2:25 p.m., an observation of the medication room was completed. A small refrigerator was observed containing tuberculin medication, containers of yogurt, two half empty bottles of soda drinks, two bottles of water with one a fourth empty. A second small refrigerator was observed containing insulin bottles, insulin pens, an ice cream sandwich, and a packaged roast beef and cheddar sandwich. An undated facility policy titled Storage of Medications, read in part, Medications must be stored separately from food and must be properly labeled. On 04/13/26 at 2:37 p.m., the DON stated the food and drink items belonged to staff and should not be stored in the medication refrigerators. |